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# Challenges and Opportunities for Ex-Offender Support Through Community Nursing

Cyril Eshareturi<sup>1</sup>  and Laura Serrant<sup>2</sup> 

## Abstract

This study was a qualitative case study underpinned by “The Silences Framework” aimed at mapping the ex-offender health pathway towards identifying “touch points” in the community for the delivery of a nurse-led intervention. Participants meeting the study inclusion criteria were quantitatively ranked based on poor health. Participants scoring the lowest and endorsing their ranking through a confirmation of a health condition were selected as cases and interviewed over 6 months. Individuals in the professional networks of offenders contextualized emergent themes. The study indicated that pre-release, offenders were not prepared in prison for the continuity in access to healthcare in the community. On release, reintegration preparation did not routinely enquire whether offenders were still registered with a general practitioner or had the agency to register self in the community. Participants identified the site of post-release supervision as the “touch point” where a nurse-led intervention could be delivered.

## Keywords

nurse led, ex-offenders, offender health, The Silences Framework, continuity in access to healthcare

## Introduction

In England and Wales, most prisoners are individuals with poor health which is exacerbated by being from marginalized sections of the population (Durcan, 2008). Compared with the general population, their health is consistently worse across a range of

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conditions (Bradley, 2009; Williamson, 2006). Indeed, most imprisoned individuals experience at least one chronic health condition, many with multiple health problems (Byng et al., 2012). Following release from prison, death from drug abuse is also a major concern due to a reduction in the ability to tolerate opioids (Farrell & Marsden, 2005).

The National Health Service Commissioning Board is responsible for the healthcare of incarcerated individuals in England and Wales; however, for individuals not incarcerated but supervised in the community by the Criminal Justice System, individual clinical commissioning groups are responsible for their healthcare (NHS Commissioning Board, 2013). Yet offenders on release use health services in a crisis-led way (Norman, 2010), are socially excluded (NHS Commissioning Board, 2013), and are hard to reach (Byng, Quinn, & Sheaff, 2014).

Moreover, while health services in prison is freely available, connecting released offenders with community health services as a health excluded group in need of tailored support is not prioritized (Eshareturi, Serrant-Green, & Bayliss-Pratt, 2014; van den Bergh, Gatherer, Fraserb, & Mollera, 2011). This issue is of disquiet as offenders are at risk of release with very little support to cope in the community and a serious health condition on release (van den Bergh et al., 2011). These health conditions and vulnerability on release generate a situation in need of attention.

In response to this, the aim of this study was to map the released offender health pathway towards identifying “touch points” in the community where nurse-led interventions could be delivered. The study was conducted in England and titled “Mapping the Offender Health Pathway: Challenges and Opportunities for Support Through Community Nursing.” It was commissioned by The Burdett Trust for Nursing with ethics approval received from the University of Wolverhampton School of Health and Wellbeing Ethics Committee and the Ministry of Justice via the National Offender Management Service.

The study key question was, “Where and how can health interventions be provided by nurses to released offenders now living in the community?” In answering this question, the study was designed to map the released offender health pathway towards identifying points in the community where nurse-led interventions could be delivered in a manner and way which would be ethical, non-stigmatising and agreeable to offenders in the community.

In line with the ethos of transparency, it is important that a declaration is made on how ex-offenders were defined. It is acknowledged that the meaning conveyed by the term *offender* is not precise as it also refers to individuals who have committed an offence but may not have been incarcerated. However, we have used the terms *released offenders* and *ex-offenders* interchangeably in referring to individuals who have been released into the community after a period of incarceration.

## Method

### *Theoretical Framework*

The study was theoretically underpinned by The Silences Framework (TSF) which is a theoretical/methodological framework suited for researching issues that are silent

from practice, under researched, and hidden from policy discourse. TSF advocates a four-stage anti-essentialist process that is designed to explore individual areas of experience by valuing individual interpretations of events (Serrant-Green, 2010). The four-stage process is comprised of identifying the silences in available evidence (Stage 1); recognizing the silences inherent in the researcher, subject and participants (Stage 2); collecting and making sense of data using methodological instruments which situate power with participants (Stage 3); and a detailed reflection on the theoretical contribution and pragmatic gains arising out of the study outputs (Stage 4).

This four-stage process is underpinned by an interpretative research paradigm which views the truth as multiple realities that are socially constructed. Accordingly, this study construed the concept of truth as a relative construct and posited that ex-offenders irrespective of prior imprisonment all have their own unique experience of what they call truth, thus deconstructing every invocation of experience as contextual and historically situated. This approach further aligns itself within the criticalist paradigm to conducting research which endorses an action-oriented methodology. This “action” could take the form of redressing power imbalances which could give voice to individuals who were previously marginalized by policy or practice which indeed, is the case with ex-offender health. Nonetheless, in adopting both an anti-essentialist perspective and a criticalist paradigm, TSF as adopted was focused on exploring the marginalized nature of ex-offender health to uncover hidden perspectives with regard to community based delivery of a nurse-led service.

This marginalized nature was explored through the concept of marginal discourses. Marginal discourses are categorized as such as they are positioned as removed from what society considers as “normal” and consequently minimally prioritized in policy (Afshar & Maynard, 2000; Foucault, 1972; Ifekwunigwe, 1997). In contradiction to hegemonic discourses, these discourses owe their importance predominantly to the harshness by which they are marginalized and opposed by mainstream society (Tremain, 2008). The study was closely aligned with this concept as it located marginal discourses in how policy and practice addressed the health needs of ex-offenders. On one hand, health policy in England and Wales does not recognize ex-offenders as a group in need of unique support on release from prison. On the other hand, there is a lack of statutory backing to enable practitioners to identify and care for these individuals as a unique group on release from prisons into their local communities (Eshareturi, Serrant, Galbraith, & Glynn, 2015). Therefore, their exclusion from policy and practice justifies their categorization as marginalized.

Although the use of TSF was aimed at uncovering the silences of offenders situated in the context of the provision of a nurse-led intervention, this framework also enabled the researcher to locate self within the study. This was pragmatically useful as this ensured that the trustworthiness of the study could be assessed in light of the silences which emerged rather than in spite them. In addition, the use of TSF further facilitated the exposure of the real world in which the study took place. This enabled the contextualisation of the realities on ground and what was not evident or reported utilising the evidence and information sources easily accessed in the current public domain. The

four stages of TSF, application, and critique are further discussed elsewhere (see Eshareturi et al., 2015; Serrant-Green, 2010).

## *Study Design*

The study was a qualitative collective case study which employed a quantitative, and parallel qualitative methods in collecting data. The target population of the study were statutory released offenders now living in the community. This population was recruited from the Local Probation Trust and accessed via their case officers. The study was introduced to participants by their case officers in the first instance and subsequently by the researcher to individuals who expressed interest to participate. Case officers and the researcher clearly conveyed to participants that there was no obligation to participate in the study and declining to participate would have no consequence on license conditions. The inclusion criteria for recruitment were:

- Participants must have been sentenced to between 2 and 8 years in prison and prior to release would have spent between 1 and 4 years in prison. These inclusion criteria were informed by the research officer of the Probation Trust who advised that these category of offenders were those who were most likely to have had a license condition imposed on them which will require maintaining contact with the service for over 6 months after release.
- Participants could be either male or female and must be above the age of 19 years which will be their present age at recruitment if they had spent at least 1 year in prison and became incarcerated at 18 which is the age of legal responsibility in the United Kingdom.

A total of 58 individuals met the study inclusion criteria. Consent to engage in the study was received from 26 of them. Questionnaires were administered in person by a researcher over the course of 4 months and were ranked on the basis of poor health. On administering and subsequently ranking the questionnaires using the rand scoring tool (RAND, 2013), only eight individuals self-identified as having a health problem which was corroborated by their low ranked scores (below 50). Consequently, these eight individuals (silent voices) were selected as cases to be followed up prospectively for 6 months. In addition, a total of 21 individuals in the professional network of offenders (collective voices) were sampled purposively and provided informed consent to participate in the study. Their roles were diverse and included probation officers, community nurses, prison healthcare nurses, probation local delivery unit lead, health service commissioners, criminal justice nursing advisor, and a prison health inspector. The collective dialogue was held with these individuals who were blinded to the data which emerged from the silence dialogue with ex-offenders.

On identification of cases (ex-offenders), semi-structured interviews were conducted in the first instance and exploratory interviews conducted subsequently over the course of the next 5 months towards identifying touch points where nurse-led interventions could be provided to ex-offenders in the community. The themes

which emerged from the semi-structured interview of an individual case informed the range of topics which were covered in the first exploratory interview with that case. Thereafter, the themes generated from each exploratory interview informed the issues explored in the next exploratory interview. At the end of the follow-up of each case at 6 months, a semi-structured interview informed by the themes which emerged from the exploratory interviews of all cases was conducted—"silence dialogue." The intent of this interview (silence dialogue) was to ensure that the themes which had emerged from following up cases over the course of the preceding 6 months were indeed representative of their views. These interviews at conclusion of follow-up led to the emergence of themes that informed the questions asked in the semi-structured interviews with individuals in the professional network of offenders—"collective dialogue."

The recruitment strategy adopted was designed in alignment with the ethos of TSF, situating study participants at the centre of the research. Accordingly, the eight cases selected were included as a consequence of self-identifying a health problem. Towards ensuring that their views did not get lost in the interpretation of the researcher, the silence dialogue was conducted to ensure that the themes uncovered were reflective of their views. This is in line with the anti-essentialist tenant of the study (Williams & May, 1996). The rationale for having the collective dialogue was in keeping with the criticalist underpinning of TSF which advocates the explanation of experience through interpretation (Scott, 1991). This dialogue enabled the contextualisation of the research findings in the reality of current service delivery.

## ***Data Analysis***

Data generated from the administered questionnaires were analysed using the scoring tool of the RAND 36-Item Short Form Health Survey 1.0 (RAND, 2013). Only the general health subscale was used, and internal construct validity was checked with the aid of a question aimed at checking if indeed the scores generated by the analysis of the questionnaires were corroborated by participants' construction of their own health. Qualitative data generated from both the semi-structured and exploratory interviews were analysed thematically to identify and report patterns of meaning (Braun & Clarke, 2006). These analyses were also supported by the use of participants' verbatim quotations which were assigned pseudonyms to ensure anonymity.

## **Results**

### ***Before Release***

Participants indicate that offenders receive good treatment for their health conditions while in prison. However, while access to health practitioners in prison was good, the delivery of health interventions in prison was inconsistent and varied from the immediate provision of services to the non-delivery of services. Importantly, participants maintain that even when offenders received treatment for a health condition in prison,

the interaction with the health practitioner and the treatment received did not prepare them for ensuring continuity in access to healthcare on release:

They had me on Warfarin for my whole sentence and I were better in prison than I were in the community, if I'm being honest, because they monitored me more. Every three to four days I've been monitored in prison. (Silence dialogue—Offender)

Most of the time people get access to treatment in prison. I don't think that it is then backed up in terms of them being educated or making it clear on how they can access such support on release. I think there's an assumption that people will register with the doctor, maybe an expectation that they know what they've been taking before and I don't think that's always there. (Collective dialogue—Probation Officer)

In the past 12 months I was an A&E sister so I had a lot of experience with ex-offenders coming into the A&E department and a lot of them have got nowhere else to go, they've come here because we're the last resort and they haven't got access to medical care. They need the drugs because they were put on a drug rehab programme in prison which was not followed up when they've been released from prison. (Collective dialogue—Acute Trust Nurse)

## ***On Release***

The on-release period was considered to begin in the immediate weeks preceding release. Participants indicate that offenders had little or no on-release support aimed at preparing them for accessing health services in the community. While some prisons provide on-release information to enable individuals to access healthcare in the community, it was uncovered that this practice is not statutory and varies across the prison establishment. Furthermore, on-release preparation for access to a general practitioner (GP) appears not to be consistent:

Between open prison and coming out? No. And I had high blood pressure, respiratory problems, asthma and stuff like that and Mirtazapine for depression. And it was like "Have you got enough meds for the next 30 days?" It wasn't "Where are you staying? Here's the number for a local GP" or anything like that. (Silence dialogue—Offender)

I had someone in the walk-in centre the other day who hadn't registered with a GP, been out of jail for a few months and he quite happily told me. I asked him "Why haven't you got a GP?" and he said "I've just come out of jail." (Collective dialogue—Acute Trust Nurse)

Clients with physical health needs I found as I say, they've been given the medication in the morning, given a couple of tablets and said "Right there you go, go and see your GP when you're released" and that's not always easy very often clients can't get an appointment for a long time or they've disengaged with the GP and they're not registered anywhere or they've moved to a different area. (Collective dialogue—Probation Officer)

## *Nurse-Led Service*

While it was uncovered that some offenders on release had the agency to navigate and access health services post release without help, it was clear from the narrative of the study participants that most offenders would need help in navigating the health system on release. Participants maintained that a nurse-led service could help released offenders navigate and access health services post release from prison if such a service was easily accessible:

Everybody coming out of prison on license has to come to the probation Office, and perhaps they could have an office set up for a nurse so they can register with a doctor because in prison the facility is not there and some offenders might go to a different area so they've got no doctor, no nurse. (Silence dialogue—Offender)

That would be good because then the nurse could do an initial assessment as to what that person's needs are and then they could be signposted to services in the community because there can be a bit of a gap there, so probably having a nurse here would encourage them, would act as the bridge between here and the GP. (Collective dialogue—Probation Officer)

With regard to the ideal location for the provision of such a service and where they felt health information could be provided on release, participants were unanimous in agreement that the site of post-release supervision would be ideal for the location of such a service:

It has to be something quite local, I would say from my standpoint it's what you're comfortable with. Because, you've been here once, it's marginally comfortable than going to new places. (Silence dialogue—Offender)

When participants were asked how they would prefer a nurse-led service to be provided, they maintained that they would like such a service to be run as an appointment service or a drop-in centre. In support of a drop-in centre, participants' comments were influenced by the nature of their "struggles" on release:

I think a drop-in because they're going to make an appointment and they ain't going to come. Because a lot of people coming out of prison are just living day to day aren't they? And they're just waiting to go back to be honest. Well half the people that come out of prison I'd say end up back in within a few months. So a drop-in centre will definitely be best I think. (Silence dialogue—Offender)

Participants posit in this context that this format recognizes the lived realities of ex-offenders on release (chaotic lifestyle) while concurrently trying to imbibe them with the agency to navigate health services independently:

I think it's a case of doing both to be honest. I think to allow people to drop in would be good because there is that chaos in their life and in the initial parts and they've got lots of



other stressors that they will see as more important in their life than their health which is fair enough. But then also if you are then building the rapport and looking at case managing someone even if it's a case of you do the primary care bit for them but case manage the secondary care appointments for them to make sure that they aren't getting dropped off waiting lists and they are getting access to stuff. I think it would be a provision of appointments for that to make sure that you're able to spend the time to be able to do that. (Collective dialogue—Offender Health Commissioner)

Importantly, participants were unanimous in maintaining that any provided service must endeavour to operate on an advisory basis as a “signposting service”:

Some sort of advisory at probation because a lot of the time you don't know whether to go to the doctors, go to the hospital or just sit it out and hope it gets better do you? Do you understand what I mean? And that's where a lot of the issues are. (Silence dialogue—Offender)

This was corroborated in the collective dialogue. Participants in this dialogue maintained that the provision of the service as an advisory and not a treatment service was in line with the ethos of not fueling dependence on the probation trust and not duplicating existing services which already exist in the community:

I think the treatment services are there and actually, its navigating people through the system. So my work with the commissioning group in (named area) would tell me that there are sufficient treatment routes but because we're not clear of what the routes are and how we navigate offenders through those routes, I think if we provided a treatment service we'd be duplicating what's already there. So it's advice and guidance stuff I think that's necessary. (Collective dialogue—Probation Local Delivery Unit Head)

## Discussion

Available evidence suggests that there is a lack of pre-release preparation aimed at facilitating the continuity in access to healthcare for offenders on release from prison (Byng et al., 2012; Care Quality Commission & Her Majesty's Inspectorate of Prisons, 2010; Dyer & Biddle, 2013). It is posited here that every contact with a health practitioner in prison needs to be supported with information which could enable the offender to continue to access healthcare on release from prison. This will be particularly useful for “revolving door offenders” who indicate that while they find the experience of imprisonment unpleasant, they recognize and use imprisonment as a period for the uptake of health interventions (Howerton, Burnett, Byng, & Campbell, 2009; Sainsbury Centre, 2008).

The intent of on-release support has traditionally been aligned with the pressing practical problems faced by offenders such as housing and income and accordingly, interventions have been focused on addressing these structural needs. This is driven by recognition that unresolved practical problems are closely related with reoffending (Maguire & Raynor, 2006; Moore, 2011). Consequently, the lack of on-release support

oriented towards accessing healthcare in the community supports the assertion of the study participants that on-release support was received for addressing their practical structural needs but that this was not replicated in the context of health.

Treatment for conditions diagnosed in prison currently varies considerably with on-release preparation for accessing care not dependent on any clinical guidance (Forrester et al., 2013; National Institute for Health and Care Excellence [NICE], 2014). Moreover, the provision of on-release support is further compromised by the overcrowded nature of U.K. prisons which mitigates against the application of good practices across the prison establishment (Prison Reform Trust, 2014). Indeed, the very notion of on-release support is challenged by the practice of moving offenders with little notice between prison wings and across prisons to manage overcrowding and the consequent risks which this triggers (Prison Reform Trust, 2014). The findings indicating that on-release preparation did not routinely include enquiry as to whether an individual was registered with a GP or had the agency to self-register is supported by available evidence. The evidence available indicates that although we know that around half of prisoners had no GP before they came into custody (Social Exclusion Unit, 2002), preparation for access to a GP on release does occur, but not on a regular basis nor for all offenders across the prison establishment (Byng et al., 2012). This preparation predominantly entails prison healthcare contacting the offender's GP with some discharge information. However, a study looking at the continuity in access to healthcare uncovered no evidence to suggest that records that were sent to community GPs from prisons were indeed received by these GPs (Byng et al., 2012).

It is clear that imprisonment leads to traumatic consequences for prisoners one of which is the diminished agency to advocate on own behalf. This lack of agency is further fueled by the fact that the prison population is overrepresented with individuals from disadvantaged backgrounds who do not have the skills to effectively engage with health services in the community (Valuri, Frank, Assen, & Morgan, 2017). This underpins the need for the period of incarceration to be used as a period of empowerment and enablement. Nonetheless, registering offenders with a GP on release should happen routinely for all offenders and the lack thereof contravenes the prison service order on the continuity in access to healthcare (Her Majesty's Prison Service, 2006).

This order mandates that prison healthcare service must help offenders register with a GP in the community where it is uncovered that an offender is not presently registered with a GP. Yet from the narratives of the study participants, it is obvious that the importance of working with offenders prior to release and on release cannot be overemphasised as this has the potential to enable the offender to plan and prepare for their continuity in access to health services in the community. However, it is clear that in practice this does not happen, and from the evidence collated herein, it is safe to posit that offenders do not feel that they get enough support to plan for what will happen after they are released with regard to their health. This underpins the need for a nurse-led service aimed at facilitating the continuity in access to healthcare for offenders on release through promoting health in the community and signposting offenders into healthcare providers as required.

## **Conclusion: Implications for Nursing**

Irrefutably, a sad reality in England and Wales is that incarceration improves access to healthcare which is not continued on release (Byng et al., 2014; Byng et al., 2012; Jarrett, Adeyemi, & Huggins, 2006). Following incarceration, continuity in access to healthcare must be prioritized. It is recognized that offenders on release are more likely to engage with health facing community interventions if these are designed to concurrently address their structural needs (Byng et al., 2012). This underpins the need to facilitate continuity in access to healthcare after incarceration through delivering health interventions in settings ex-offenders now living in the community visit for other services.

A study on the provision of a nurse-led addiction service in three probation hostels in England indicated that the provision of a nurse to orchestrate care for supervisees led to a reduction in heroin use within the hostels (Payne, 2001). While this study was limited by the fact that a control group was not included, the study nonetheless indicated that the nurse-led service contributed to significant improvement in the health of supervisees as the intervention led to an associated reduction in the use of heroin within the premises.

Internationally, the use of a nurse-led intervention in facilitating the continuity in access to healthcare for offenders on release from prison has also been demonstrated. A randomised control trial on nursing case management towards hepatitis A and B vaccine completion among 600 recently released offenders in the United States indicated that nursing intervention improved vaccine completion in the community (Nyamathi et al., 2015). Similarly, a study investigating the transitional healthcare for offenders released from U.S. prisons indicated that the majority of transitional healthcare planning was coordinated by registered nurses and that this planning enhanced continuity of care by decreasing acute-care episodes, controlling the spread of communicable diseases, increasing access, and reducing the financial burden to the health economy (Flanagan, 2004).

The findings of this study corroborated by the aforementioned studies indicate that nurses are well placed in the community as a conduit for facilitating the continuity in access to healthcare for offenders following incarceration. Consequently, the use of nurses in promoting and facilitating health access in the community for offenders following incarceration is a strategy that could improve both the life and health chances of these individuals through reducing offender health marginalization as a consequence of increasing access to healthcare.

Finally, this study contributes to knowledge by identifying the site of post-release supervision as the “touch point” where a nurse-led intervention could be delivered in the community to facilitate the continuity in access to healthcare for offenders post incarceration. Furthermore, this study indicates that pre-release, offenders are not prepared in prison for the continuity in access to healthcare in the community, and on release, reintegration preparation does not routinely enquire whether offenders are registered with a GP or have the agency to register self in the community. This further reinforces the need to explore the use of nurse-led community focused interventions as

tools for facilitating the continuity in access to healthcare for offenders on release from prisons.

### Author(s) note

Cyril Eshareturi is now affiliated to University of Bradford, UK.

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